International Journal of Medicine and Pharmaceutical Sciences (IJMPS)
ISSN(P): 2250-0049; ISSN(E): 2321-0095
Vol. 4, Issue 2, Apr 2014, 101-112

VIOLENCE AGAINST EMERGENCY CARE STAFF IN BASRA HOSPITALS

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ABSTRACT

Introduction: Emergency care service is one of the professions affected by workplace violence. It is not a new phenomenon but in recent years, much greater emphasis has been placed on the problem. Despite the fact that the problem is under attention worldwide, little is known about it in emergency departments in Iraqi hospitals.

Aim: This descriptive cross-sectional study aims at investigating the problem of violence against emergency care staff in Basra hospitals.

Method: The study was conducted in a cross-sectional methodology setting targeting the emergency care staff in Basra hospitals to elicit doctor and paramedical staff's responses of experience to workplace violence. The study involved 198 staff members. This was divided by the 6 hospitals of Basra City. At each of the six emergency departments, the sample from targeted population was convenience one. A pre-structured questionnaire was translated with a very limited modification and used.

Results: About 48.7% of the respondents had faced verbal violence, 24.6% faced physical violence, and 13.6% had faced hospital-property damage/ theft. Most victims did not take an action after the end of the violence incidents. About 62.8% of respondent victims do not/rarely think about violence when they do not mean to, and most of them (89.8%) do not/rarely have dreams about violence. About half of the victims do not to remove the subject from memory and a approximately similar percentage of them do not talk about violence, while third of them avoid letting themselves get upset when they think about/being reminded of violence incidents.

Conclusions: In emergency departments of Basra hospitals, verbal violence/ intimidation is the most common, followed by physical violence, and the least frequent is hospital-property damage/ theft associated with violence and the rates lie in the middle of international range. Violence, which worries the victims most, usually occurs during the daytime work shifts and the main perpetrator is a male, who is mostly the patient's family member, relative, companion or friend. Workplace violence victims either do nothing as an immediate response to the incident or take limited actions and they, often, do not take an action after the end of the incidents. Furthermore, violence does not leave long-term consequences in Iraqi professionals.

KEYWORDS: Violence, Emergency Department, Basra

INTRODUCTION

The workplace violence has special relevance for the healthcare workers [1, 2]. Emergency care service staff is one of the professions most affected by this risk [1]. Violence against emergency care staff is not a new phenomenon but in recent years much greater emphasis has been placed on the problem [3]. Patients and their relatives exposed to stress caused by accidents or illness might use violence against healthcare staff and interfere with quality healthcare [4, 5]. A number of

official reports, media stories and international initiatives have focused attention on the problem worldwide. However, it is not clear whether violence has in fact become more prevalent. Reported rates of violence against emergency care staff are increasing and studies of violence and aggression to health service staff have largely focused upon accident and emergency units[6]. A considerable percentage of emergency care staff report at least one incident of non-physical violence and less percentage report at least one incident of physical violence [7]. The problem is international and Table (1) shows some incidence figures of violence "an act of aggression directed toward emergency care staff at work, on duty or outside work due to reasons relevant to job. It may range from the use of offensive or threatening language, harassing, coercive behavior to physical assault, that causes physical or emotional harm or even homicide[8]" from different countries.

Table 1: Incidence Rate of Physical and/or Non-Physical Violence among Emergency Care Staff in Some Countries

S. No	Author	Country	Year	Incidence Rate among Respondents
1	Galián Muñoz I et al[1]	Spain	2012	21.8%
2	Magnavita N et al[2]	Italy	2012	One out of three
3	Fujita S et al[4]	Japan	2012	36.4%
4	Ahmed AS[5]	Jordan	2012	37.1%
5	Lanza ML et al[7]	USA	2006	27.8%
6	Badger F et al[6]	UK	2004	Just over 50%

Source: Prepared by the researcher

Although emergency care staff is one of the professions most exposed to violence, the risk distribution is not homogeneous. Significant differences are found according to marital status, age, hospital characteristics, type of service, profession, shift and seniority in the profession [1, 5]. However, the factors the staff believe most contribute to violence are negative societal image of emergency care staff and poor support from hospital authorities [5].

Currently, workplace violence is recognized as a violent crime that requires targeted responses from employers, law enforcement, and the community [8]. In spite of the facts above, only about one third of the emergency care staff, whom are exposed to violence, report it; half of those that do not, think it is useless to do so, while one third think they can handle the incidents without help. This violence has made a considerable percentage of the affected emergency care staff report that they consider leaving their job and feel their quality of work decreases because of the violence[5]. Because of a shortage of standardized measurement and reporting mechanisms for violence in healthcare settings, data are scarce. At present little is known about the problem in emergency departments of in Iraqi hospitals. This has motivated the researcher to conduct this study.

OBJECTIVES

This descriptive cross-sectional study aims at investigating the problem of violence against emergency care staff in Basra hospitals. The objectives are:

- To determine the incidence and sources of different types of violence
- To determine some characteristics of violence
- To determine reactions of victim emergency care staff

METHODS

This study was conducted in a cross-sectional methodology setting targeting the emergency care staff in Basra

hospitals to elicit doctor and paramedical staff's responses of experience to workplace violence. The sample size was calculated to be 198 staff members. This was divided by the 6 hospitals of Basra City. The share of each hospital was 33 emergency department staff members. At each of the 6 emergency departments, the sample from targeted population was convenience sample. The number of respondents was 191 (96.46%).Basra is the capital of the south of Iraq covering approximately 19070 square kilometers with an estimated population of 2531997 million people [(9)]. The study population included the doctors, paramedical staff, and other emergency service staff from emergency care units of the hospitals in Basra City Centre. During the time of the study, the total population of interest composed of 306 senior house officers, 134 house officers and 187 paramedical staff, who work in the emergency rooms of the 6 governmental hospitals of the City[(10)]. As far as workplace violence is a term refers to violence that is associated with work, all forms of hostile behaviour occurred to the emergency staff in the emergency rooms or in other places inside the hospital or outside it were investigated. A questionnaire used by Boyle et al [(11)] to explore staff's experience of violence was translated with a very limited modification to fit the situation in Iraq. It investigated the workplace violence as defined by Tolhurst et al[(12)] -verbal violence, hospital-property damage/ theft, intimidation, physical violence, sexual harassment, and sexual assault. The questionnaire was piloted on ten of the candidate population. Following the return of the questionnaires and comments, changes were made to the form. The major change made was that omitting the questions related to sexual harassment and sexual assault. That was because none of the pilot study population agreed to answer the relevant questions. Moreover, an advice was given by the Research Approval Committee in Basra Directorate of Health to remove those questions.The questionnaire forms had been then distributed by the researcher to the targeted staff in Basra hospitals. Respondent staff completed the questionnaire and returned it. Data analysis was undertaken using SPSS (Statistical Package for the Social Sciences) Version 19.0. Descriptive and analytical statistics were used to analyse the data. Chi^2 or Fisher's exact tests were used to compare differences between the types of violence investigated. The results were considered significant if the p value was <0.05. Ethics approval for this study was granted by the Research Approval Committee in Basra Directorate of Health.

RESULTS

Table (2) presents the sociodemographic characteristics of the respondents. It shows that more than two thirds of the respondent population were males. The age of about 73% of them was 30 years or less. About 67% of the study population have spent 10 years or less working in the health service sector. About 90% of them were paramedical staff, mainly nurses.

Table 2: Distribution of the Study Population According to Some Sociodemographic Characteristics

Characteristic	Frequency	Percent
Gender		
Male	132	69.1
Female	59	30.9
Age (Years)		
≤ 20	39	20.6
21 - 25	28	14.4
26 - 30	73	38.1
31 - 35	12	6.2
36 - 40	12	6.2

Table 2: Contd.,

> 40	28	14.4
Duration of Work (Years)		
≤ 5	67	35.1
6 - 10	61	32.0
11 - 15	32	16.5
16 - 20	24	12.4
> 21	8	4.1
Occupation/Academic Achievement		
Nurse/ Nursing preparatory school	104	54.6
Doctor assistant/ Technical institute diploma	39	20.6
Doctor/ Bachelor	20	10.3
Laboratory assistant/ Diploma in lab services	20	10.3
Pharmacy assistant/ Diploma pharmacy	8	4.1
Total	**191**	**100.0**

Table (3) shows that about 48.7% of the respondents answered they had faced verbal violence/ intimidation, 13.6% had faced hospital-property damage/ theft associated with violence, and 24.6% faced physical violence. These differences were found to be statistically significant. Also, regarding the frequency of exposure to each type of violence during the last 12 months, it can be noticed that verbal violence/ intimidation is more frequent than hospital-property damage/ theft associated with violence or physical violence. Again, these differences were found to be statistically significant.

Table 3: Answers of Respondents to Questions about Exposure to Workplace Violence during the Last 12 Months and its Frequency

Variables	Type of Violence			Chi^2	P-Value
	Verbal[§]	Property Damage^	Physical		
History of exposure:					
Yes	93 (48.7%)	26 (13.6%)	47 (24.6%)	59.758	0.0001
No	98 (51.3%)	165 (86.4%)	144 (75.4%)		
Frequency of violence:					
Once a year	4 (4.3%)	18 (69.2%)	35 (74.5%)		0.0001
Few times	9 (9.7%)	6 (23.1%)	4 (8.5%)		
About once/ month	21 (22.5%)	2 (7.7%)	8 (17%)	99.239	
About once/ week	26 (28.0%)	0 (0.0%)	0 (0.0%)		
Almost every day	33 (35.5%)	0 (0.0%)	0 (0.0%)		

[§] Almost all respondents linked intimidation to verbal violence incidents. Answers were mostly the same. Therefore, intimidation is joined to verbal violence in the results.

^ Answers relevant to this type of violence, in the following results, represent the characteristics of hospital-property damage only. Respondents could not answer questions related to hospital-property stealing.

Table (4) shows that during the verbal violence/ intimidation incidents, the level of fear was mostly (47.3%) mild apprehension, the hospital-property damage/ theft associated with violence incidents mostly (34.6%) quite apprehension, and physical violence incidents mostly (49%) fright. These differences were found to be statistically extremely significant.

No any statistically significant difference between the 3 types of violence could be noticed for the other characteristics tested. Table (5) shows the answers to the questions relevant to these characteristics. It can be noticed that

- Violence occurred during the daytime work-shifts more than the nighttime ones;
- Most of incidents occurred in the usual work location;
- In most of the incidents, the perpetrator was the patient's family member, relative, companion or friend;
- The gender of the main perpetrator in the worried most violence incident was male;
- Most respondents do not think that there was any underlying factor that participated in the occurrence of the incident; and
- About half of the respondents, who faced violence, did nothing as an immediate response to the incident.

Table 4: Answers of the Victims to the Question "What was your Level of Fear during the Worried-Most Incident?"

Variables	Type of Violence			Chi^2	P-Value
	Verbal[§]	Property Damage^	Physical		
None	23 (24.7%)	6 (23.1%)	0 (0.0%)	64.603	0.0001
Mildly apprehensive	44 (47.3%)	7 (26.9%)	0 (0.0%)		
Quite apprehensive	20 (21.5%)	9 (34.6%)	19 (40.4%)		
Frightened	2 (2.2%)	2 (7.7%)	23 (49%)		
Very frightened	4 (4.3%)	4 (7.7%)	5 (10.6%)		

Table 5: Answers of the Victims to the Questions of the Workplace Violence

Question	No.	%
When did a worried-most incident, of each of the following types of violence, occur?		
During daytime work	103	62.05%
During nighttime work	63	37.95%
Where did a worried-most incident, of each of the following types of violence, occur?		
Usual work location	149	89.76%
Other place inside the hospital	11	06.63%
Others	6	03.61%
Who was the main perpetrator of the worried most violence incident?		
Service user	34	20.48%
User's family, relative, companion or friend	119	71.69%
Other professional or work colleague	1	0.60%
Others	12	7.23%
What was the gender of the main perpetrator?		
Male	157	94.58%
Female	9	5.42%
Do you think there were any underlying factors that participated in the occurrence of this incident? (e.g. alcohol intoxication,		

psychological health problem, etc) Yes No	67 99	40.36% 59.64%
What was your immediate response to the violence? Did nothing Called the Hospital security/ police Asked for colleagues help Others	 81 74 8 3	 48.79% 44.58% 4.82% 1.81%
Total	**166**	**100%**

From Table (6), it is clear that most of respondent victims of violence did not take an action after the end of the violence incidents.

Intermediate-Term Consequences

Table 6: Answers of the Victims to the Question "How did you Respond to Work-Associated Violence Incidents, Which you Exposed to, after they Ended?"

Response	Percent				
	Never	One-Few Times	Mostly	Always	Total
Submitted a claim to the hospital management/ Directorate of Health headquarter	63.4	26.8	00.0	09.8	100.0
Submitted a claim to the police	51.2	34.9	09.3	04.7	
Used the tribal law to deal with the incident	73.3	08.9	08.9	08.9	
Took days off work	77.8	08.9	13.3	00.0	
Moved to an other job/ position in the hospital or another hospital	86.7	13.3	00.0	00.0	

It can be seen in Table (7) that about 62.8% of respondent victims do not/rarely think about violence when they do not mean to, and most of the (89.8%) do not/rarely have dreams about violence. In the same time, about half of the respondents answered that they do not to remove the subject from memory and a approximately similar percentage of them do not talk about violence, while third of them avoid letting themselves get upset when they think about/being reminded of violence incidents.

Long-Term Psychological Consequences

Table 7: Long-Term consequences

Consequence	Percent				
	Never	Rarely	Some Times	Mostly	Total
I usually think about violence when I do not mean to	31.4	31.4	13.7	23.5	100.0
I usually have dreams about violence	74.4	15.4	10.3	00.0	
I used to try to remove the subject from memory	48.9	12.8	12.8	25.5	
I try not to talk about violence	47.5	20.0	07.5	25.0	
I usually avoid letting myself get upset when I think about/being reminded of violence incidents	29.3	13.8	25.9	31.0	

DISCUSSIONS

Regarding the sociodemographic characteristics of the respondents, the percentage of males reflects the fact that there is a shortage in female nursing-staff in Basra hospitals during the period of study. The considerable percentage of young junior staff may be a facilitating factor for entering in conflicts that can lead to violence; when the candidate to work in emergency rooms are not trained efficiently on communication skills. They acquire these skills gradually during their work as a part of the hidden training curriculum. Because the sample was a convenience (non-probability) one, the distribution of the respondents, according to occupation/ academic achievement, differs greatly from the distribution of the emergency department staff population.

In the last 12 months, the rates of emergency department staff, who answered that they were subjected to violence, are 48.7% verbal violence/ intimidation, 13.6% hospital-property damage/ theft associated with violence and 24.6% physical violence. Considering representativeness, Basra, certainly, does not represent Iraq. But, the results of the study can give a rough idea about the size of the problem in the country. The rate lies in the middle of international range above.

Regarding exposure of emergency department staff to verbal violence, it was stated that its rate internationally varies from 21–82.4% [(11)]. The rate reported in the current study lies nearly in the middle.

When physical violence is considered, researchers from the Middle East found that its incidence in the 6 months proceeded the study was 18.3 % [(5)], in Turkey 8.5% [(13)] and in Hong Kong it was reported as 18%[(14)].

No data relevant to violence-associated hospital property damage/theft were found in the literature for comparison. The available data are relevant to the victim's property damage/theft. Amendment from victim's property to hospital property was done in the light of the results of pilot study.

Figures in this study seem to be lower than many figures in other places in the world. This is probably due to difference in culture, where the staff of emergency department in other countries may remember or document simple violence incidents more than the respondents in the current study do.

The differences in the incidence of these types were found to be statistically significant (P= 0.0001). That is to say, Workplace violence against emergency department staff in Basra hospitals is significantly more frequently verbal, followed by physical, and the least frequent is hospital property damage/theft. A sequence that seems to be expected and does not differ from the trend of these types of violence in other countries [(2, 4, 5, 7)]

Verbal violence/ intimidation was faced by respondents from once/ week to daily in a percentage of about 63.5%, while hospital-property damage/ theft associated with violence and physical violence were faced from once to few times per year in 92.3% and 83% respectively. These differences were found to be statistically significant (P= 0.0001). Again this finding seems to be logical, when the relatively mild form of violence occurs more frequently than the relatively more sever form. These results differ from the findings of Malcolm Boyle et al[(11)], who found most of the study respondents who experienced verbal abuse and intimidation a few times in the last 12 months. Just over 3% of paramedics reported experiencing verbal abuse on a daily basis and approximately 12% about once a week.

In all types of violence, which worried the victim most, incidents occurred during the daytime work shifts more than the nighttime work shifts. This has been explained to be because of the fact that daytime work shifts represent the time of high activity and interaction with patients [(15)]. These findings do go with Waleed Zafar et al's findings [(16)]. Most of the violence incidents occurred at the place of work other than other places, inside or outside the hospital. This is expected as far as it is assumed that the incidents occur as an immediate temporary reaction to mutually unmet behavioral expectations.

This assumption is supported by the finding that most respondent victims do not think that there was any underlying factor that participated in the occurrence of incident in all types of violence. A similar finding was reported by Cassie B. Barlow and Anne G. Rizzo, earlier at the end of last century, that attacks were more likely to occur in the emergency room than in any other section of the hospital [(17)].

The main perpetrator, in the incidents that worried the respondents most, was the emergency care service user's family member, relative, companion or friend. The service user themselves come in the second degree. This what was stated by Waleed Zafar et al that emergency department healthcare workers are relatively frequent victims of violence perpetrated mainly by patient's relatives (69.9% in verbal and 63.6% in physical violence) and then by the patients themselves (16.1% in verbal and 20.4% in physical violence)[(16)].

The main perpetrator in the worried most incidents was male in all types of violence. This finding goes with the belief that men are responsible for the vast majority of violence. The findings here differ from those reported by Terry Kowalenko et al that men perpetrated only 52% of assaults and 63% of physical threats[(18)]. This difference is probably can be attributed to sociological and cultural differences between the two communities; where in Iraq, men are socially dominant. However, Mohamad Kitaneh and Motasem Hamdan found, in spite of that males were the main perpetrator in physical violence (76%), females were the main perpetrator in verbal violence (63.6%) [(19)].

It was stated by Needham I et al that despite differing countries, cultures, research designs and settings, staff's responses to patients' aggression are similar [(20)]. In this study, almost all respondents, who faced violence, either did nothing as an immediate response to the incident or they called the hospital security/ police, which in fact is a very limited action, when the security guards/ police officers' role, only, stop violent behaviours without any consequences. This probably refers to that even if the incident may seem worrying to the victim staff, it does not lead them to take a serious action to stop/ deal with it. It can be due to the perception, by the staff, that exposure to workplace violence is part of the nature of their job. This finding goes with what Cheshin Arik et al's. They found that victim staff's response ranged from ignoring the incident, giving in to the violence, or calling security [(21)]. They also reported that the higher the perception of threat, the more likely the staff was to give in to the perpetrator's anger and/or the higher the likelihood that the response would be to call security, i.e. the staff recognizes perpetrator's anger at varying levels and responds accordingly[(21)].

The graduation in the level of fear during the incidents, reported in this study, was consistent to the graduation in the level of violence. This seems to be logical and agrees Cheshin Arik et al, who reported that the expressions and magnitudes of the perpetrator's anger were directly correlated with the victim staff's fear level, hence with their response to violence [(21)].

Most of respondent victims of violence did not take an action after the end of the violence incidents. This finding agrees what was found by Terry Kowalenko et al; they stated that for the violent events, 42% of the incidents reported to hospital authorities and only 5% of assaults were reported to police [(18)]. It was reported that the reason behind this underreporting was because there are barriers to reporting violent events exist and include confusion about what events should be reported, lack of time to complete reports, and lack of feedback from management and administration about the reported event[(22)]. Respondent victims in the Kitaneh and Hamdan's study answered that they did not take an action because it was useless (from their experience no action would be taken), it was not important, they were afraid of negative consequences or fear of feeling guilty or ashamed, or they did not know to whom they should report[(19)].

The researcher here does not believe that this is the reason in the underreporting findings of the current study; it simply may be because the victim staff consider violence incidents as a part of their work.

Respondent victims' answers about long-term psychological consequences of exposure to workplace violence showed that a considerable percentage of them do not/rarely think about violence, do not/rarely have dreams about it, do not/rarely try to remove the subject from memory, do not/rarely talk about violence, and mostly/ sometimes avoid letting themselves get upset when they think about/being reminded of violence incidents. The situation here differs, to some extent, from findings reported by other researchers. Magnavita and Heponiemi documented psychological impacts of violence. These included anger, disappointment, anxiety, distress, intention to move to another place of work or to perform professional duties in a different way, and high psychological disorders scores [(2)]. Kitaneh and Hamdan stated that the impact of workplace violence and its potential threat was an issue that most of the study respondents contemplated at least occasionally. There were forms of protection sought. These include obtaining a gun, a knife, a concealed weapon license, and carrying mace or a club and most used a security escort. Considering leaving the hospital, emergency medicine, or location of practice because of being a victim of workplace violence were found to be impacts. One percent sought psychological support, and 16% went to a course on violent patients because of their experience with violence in the workplace[(18)]. Needham I, et al. reported that the most frequent psychological consequences of violence were anger, depression, fear or stress, headache/ fatigue, and frustration. A considerable percentage of victims sought some sort of treatment (including psychological), reported persistent health problems, and reported subsequent changes in their work status including restrictions in work, work absences, or transferred to another location [(19)]. This difference, probably, belongs to the fact that Iraqi people have faced variable work, social, and domestic types of violence of considerable levels during the last 35 years that has made such workplace violence does not leave long-term psychological consequences in Basra emergency department staff victims .

CONCLUSIONS

In emergency departments of Basra hospitals, verbal violence/ intimidation is the most common, followed by physical violence, and the least frequent is hospital-property damage/ theft associated with violence and the rates lie in the middle of international range. Violence, which worries the victims most, usually occurs during the daytime work shifts and the main perpetrator is a male, who is mostly the patient's family member, relative, companion or friend. The graduation in the level of fear during the incidents, reported in this study, is consistent to the graduation in the level of violence.

Workplace violence victims either do nothing as an immediate response to the incident or take limited actions and they, often, do not take an action after the end of the incidents. Furthermore, violence does not leave long-term consequences in Iraqi professionals.

LIMITATIONS

- It was assumed that respondents in this study responded to the questionnaire in a reliable manner. There is no way at the disposal of the investigator, however, to verify such assumption. It might be biased by the potential inaccuracy of self-reported data compared to objectively verified one.
- The respondents who answered the questionnaire might not have a clear recollection of all the incidents during the year preceded the study. If the respondent was unable to recollect all incidents, the questionnaire may not have been answered in a credible and factual manner. People usually tend to remember important events.

The retrospective nature of the study may mean, because of the respondents' recall accuracy, that the results are not a true representation of the problem in Basra. Memories, especially regarding events like a verbal attack, might be less memorizable, leading to distorted time perception: events that happened more than a year ago might be misremembered to have occurred more recently.

- The sample was not randomly selected. So, from education level and type of occupation points of view, the sample was not representative. This could make the generalizability of the study results limited.

RECOMMENDATIONS

- The problem needs more detailed investigation in Iraq to determine its frequency, distribution, and determinants.
- Training, on how to deal with workplace violence, is a topic that needs to be added to the initial and continuous training curriculum of emergency department staff in Iraq.
- More legislations need to be put to prevent workplace violence against health staff in general and specifically the emergency department staff.

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